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Briefing: Medicaid Managed Care in the Era of Health Reform
Kaiser Family Foundation
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DIANE ROWLAND: Welcome to the Kaiser Family Foundation and to our event today on Medicaid Managed Care in the Era of Health Care Reform. We're very pleased to have you all with us, and thank you for coming in on a beautiful day to hear more about health policy, and we hope you will find it a fruitful use of your time.

I'm Diane Rowland, the Executive Vice President of the Kaiser Family Foundation, and I serve as the Executive Director of our Kaiser Commission on Medicaid and the Uninsured. We're very pleased today to be able to look at these issues that are really the emerging issues in the delivery system reforms that are going on across the country, and especially to look at how some of these changes in the delivery system are affecting people with disabilities, those with some of the highest needs, and among some of, of course, our highest-cost patients in the health care system as well.

With the expansions anticipated to go on with the Affordable Care Act, we know that managed care is going to play a very important role in extending both the coverage and access to the new populations, as well as continuing to serve those already in the Medicaid program. So we're really looking forward today to this discussion of what is going on in California to begin with, and then later how that fits with more national trends and national services.

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I am pleased that we always try to start with a bit of an overview, and we're going to start with an overview of Medicaid managed care with Julia Paradise from our Kaiser Commission staff, setting the framework for our discussion today.

Then, we're going to turn to a panel discussion that really reports on some new research and some of the changes going on in the state of California, as California transitions seniors and persons with disabilities to Medi-Cal managed care, and Carrie Graham, the Assistant Director of Research at Health Research for Action in the UC Berkeley School of Public Health, is going to really provide us with some findings from some work she's doing at assessing how that transition is going and what some of the lessons for the future are.

Then, we're going to have a video presentation by Jane Ogle, Deputy Director of the Healthcare Delivery Systems at California's Department of Healthcare Services, to give us the state perspective on the challenges and the opportunities that they're facing with this transition.

Then, because we're able to have one of the major CEOs of one of the health care plans in California with us today, Howard Kahn is going to provide us with an overview of some of the issues from the plan perspective.

Then, we're going to turn to try and put these findings and these experiences in context of what the implications are

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for future care transitions and coverage expansions across the country.

I'm very pleased that we have with us Trish Riley, Senior Fellow at the Muskie School of Public Service at the University of Southern Maine, and a lecturer from George Washington University, but, even more importantly to me, a member of the Kaiser Commission on Medicaid and the Uninsured, as well as a member of MACPAC, so Trish wears many hats and we're pleased to have her join us for her many different perspectives, not just from Maine, but as a national leader on many of these policy issues.

Meg Murray, who is the CEO of the Association for Community Affiliated Plans will, of course, give us more insight into the plan issues at a national level, and then Kevin Prindiville, a lawyer from California serving as the Executive Director of the National Senior Citizens' Law Center is going to provide some commentary, again, on the national perspective and lessons from California of these transitions.

It's a packed agenda, but I think it's packed with really great information and great perspectives, and so we're going to set it in motion, and then at the end hopefully be able to have some time to really engage with you in questions and discussion.

Julia, let's go forward.

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JULIA PARADISE: Thanks, Diane. Good afternoon, everyone. I'm going to take just a few minutes to provide some context for today's panels and, as Diane said, to summarize some of the trends in managed care at the national level.

I want to begin with just a couple of simple, but really important points, to remind us both of the scale and the stakes of what we're talking about when we talk about Medicaid. The program now covers over 65 million people at some point during the year. That's more than 1 in every 5 Americans.

Point number one is that what happens in Medicaid affects a lot of people, and that number will increase by millions as the states that are moving forward in January under the ACA's expansion of the Medicaid program begin to implement.

The second point I want to make is that the population the Medicaid program serves is, of course, as pretty much everybody here knows, very poor and it's a population that includes many individuals with very significant health care needs. These include people with multiple chronic conditions like heart disease and diabetes, as well as people with physical disabilities, and we're also talking about individuals with severe mental illnesses and people with serious developmental and cognitive disabilities like Down syndrome and autism, traumatic brain injury, and also dementia.

As we consider transitions to managed care in Medicaid, this profile of the Medicaid beneficiary population is

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important to keep in mind. With that, we'll look at some national trends.

As you can see here – well, before I talk about these data, just a little bit of definition stuff. Comprehensive managed care in Medicaid, which is the term we're talking about here, takes two different forms in Medicaid. In risk-based managed care, states contract with health plans, known as managed care organizations, or MCOs, in Medicaid on a prepaid, capitated basis to deliver Medicaid services to enrolled beneficiaries, and this is the dominant model of managed care in Medicaid, and the one we'll mostly be talking about today.

The other model, also important, is a managed fee-for-service approach known as primary care case management, just by way of background.

Looking back over the last decade, we can see that Medicaid enrollment in risk-based managed care has been climbing steadily, both in raw numbers and as a share of total Medicaid enrollment, and today more than half of all Medicaid beneficiaries receive their care from MCOs.

Did I skip one? Yes.

The penetration of risk-based managed care in Medicaid varies quite widely across the states. A number of the states, as you can see here, the white ones, have no MCOs, but in half the states, more than 50-percent of all Medicaid beneficiaries are enrolled in comprehensive managed care plans, and many of

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these states, including California, which we are going to focus on today, rely substantially more heavily on MCOs to serve their Medicaid populations.

States are continuing to broaden their use of managed care in Medicaid in a variety of ways. Most relevant to today's briefing, numerous states are expanding Medicaid managed care, increasingly on a mandatory basis, to beneficiaries with more complex health care needs, including people with disabilities and individuals who are dually eligible for both Medicare and Medicaid.

In addition, a growing number of states are providing long-term services and supports as well as acute care through managed care arrangements.

At the same time that states are expanding managed care within their current Medicaid programs, the states moving forward with the ACA Medicaid expansion to low income adults are expected to rely heavily on MCOs to serve these new enrollees.

Also fueling managed care activity in Medicaid and giving rise to new delivery system life forms are a multitude of initiatives, some driven by the states and some plan-driven, to improve care coordination and integration, especially for more medically complex and high-need Medicaid beneficiaries. These are things like patient-centered medical homes, health homes, and accountable care organizations, among many others.

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Finally, state demonstrations to integrate care and align Medicare and Medicaid financing for dual-eligible beneficiaries represent a new sphere of expansion for risk-based managed care. Today, about 13-percent of the roughly 9 million dual-eligible beneficiaries, and these are the poorest and frailest of beneficiaries in both programs, are enrolled in managed care for their Medicaid services. Under the demonstrations, there are now 21 state proposals. As many as 2 million dual-eligible beneficiaries could be in managed care arrangements, largely capitated arrangements, for all their services, Medicare and Medicaid alike.

The momentum of all these developments is in the same direction toward an increasingly large role for Medicaid managed care in serving high-need populations. Our first panel on a major managed care transition in California offers us a great case study of what such transitions involve and require, and it's my pleasure now to turn things over to Carrie Graham. Thanks.

CARRIE GRAHAM: Good morning, or good day, everyone. Thank you for coming today. My name is Carrie Graham, and I am from the UC Berkeley School of Public Health, and I've been leading a team over the last about year and a half studying one of the first phases of health care reform in California, which is the transition of seniors and people with disabilities, who have Medi-Cal-only, to Medi-Cal managed care plans.

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We believe this transition is really a test case, if you like, that really helps us identify some challenges and anticipate lessons learned and successful strategies that health plans, providers, and community-based organizations took to implement this transition. We also think it could be an interesting lesson for other states and other phases of the Medicaid expansion in California.

Seniors and people with disability in California were one of the last Medi-Cal populations who are Medi-Cal-only, or one of the last populations to still be on fee-for-service Medi-Cal. They were originally exempted from the mandate to managed care because of concerns about disruptions in care, or problems with accessing care in managed care, but that all changed with the implementation of the 1115 Waiver. For the first time, seniors and people with disabilities were mandated into managed care.

The state implemented this transition on quite a really tight timeline. Over 12 months, they transitioned about a quarter of a million beneficiaries who needed to choose a plan or be assigned to a plan by their birth month.

Now, Medi-Cal-only seniors and people with disabilities, or we'll call them SPD, are distinguished from dually eligible beneficiaries because they are mostly adults with disabilities, and only 16-percent seniors. They have high utilization rates and, although they account for about 24-

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percent of the fee-for-service population, also account for about 42-percent of spending and, like dually-eligibles, we're talking about a population that has very complex care needs, rare disabilities, problems with functional limitations. About two-thirds in 2010 received treatments for three or more conditions. About almost 40-percent in 2010 received care for six or more conditions.

So, we believe the lessons learned from this transition can be helpful in terms of informing transitions of more general Medi-Cal populations, such as the 500,000 beneficiaries who have been transitioned under the low income health plan in California, and then, coming up in January, we'll have almost half a million beneficiaries who are dually eligible who will be transitioned to managed care plans, called Cal MediConnect.

Today I'm here to talk about our study, which focused primarily on the perspective of organizations that serve SPD beneficiaries and their experiences during the transition. We conducted almost 60 interviews in three distinct counties that represent discrete areas of California. We interviewed medical providers, health plans, even providers like pharmacists and durable medical equipment providers, advocacy groups, and community-based organizations that serve SPD.

As I've said, the goal of the study was to really examine an organizational perspective. There had been studies already that looked at beneficiary perspective, and we wanted

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to see what organizations said about how care to SPD were affected, and what the challenges were faced by their organization and, most importantly, what were the lessons learned, and what were the successful strategies they used to overcome some of these challenges to inform future transitions.

The first theme from our study, and there are a lot of themes that are in the written brief that I won't talk about today, but the first one is a data and information sharing that a transition like this requires. I'm not going to go through all of this for time's sake, but this was a complex web of information and data being transitioned across entities. DHCS had to inform beneficiaries. Beneficiaries had to get their information about their choice back to DHCS. The state had to transfer a lot of information to health plans and providers.

It was really a testament to the state in terms of being able to coordinate this, the timing of all of this data flowing across entities and coordinating that with the health plans.

There were some challenges. One of the biggest challenges that came up for state and health plans was incomplete beneficiary contact information. A large percent of beneficiaries did not have complete contact information. You can imagine, the state had to notify beneficiaries, which they did by phone and mail, and this was difficult.

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One thing the state did was they worked to try to update as many telephone numbers and addresses as they could, but by the time it got to the health plans, there was still missing information. This made it difficult for the health plans, who had to call beneficiaries and conduct health risk assessments. They had to get the medical card and notify beneficiaries that they were in the plan.

One of the things that a health plan reported doing was working with county social services agencies and pharmacies to try to fill in some of those gaps in beneficiary contact information.

Another major challenge to data and information sharing were the beneficiary medical histories. Medical histories and prescription histories needed to be transferred from the state to the health plan, and then to the provider. Privacy considerations make it so the state cannot transfer that information before a beneficiary is enrolled in the plan, but beneficiaries began using the plan on the date that they enrolled. This might not be a problem in the general population, but SPD are using care quite quickly after their enrollment. They have urgent care needs. The state was able to get, for the most part, medical histories to plans about eight days after the beneficiary enrolled, but there were a lot of reports of people seeking care before that happened.

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One of the recommendations that came out of this research was to not delay the transition, but to allow maybe a waiting period between the time that the beneficiary was enrolled and the time they began using the plan. Plans wanted to use this information to improve their readiness, to be able to recruit fee-for-service doctors who the beneficiary might have been seeing, and to be able to pre-approve services, so this was a missed opportunity.

Another thing that came out of this research, a major thing, was adequate provider networks. This was a huge task of the plans, and they did expand their provider networks. This was overseen by DHCS and CMS, but there were challenges. Some reports of some of the primary care doctors in the pool not being experienced with the complex care needs of the SPD population. Difficulty recruiting specialists has been an age-old theme in Medicaid, and we saw here there were especially issues with not having the specialist who had expertise in these rare or unusual disabilities.

Then, one other major theme that we heard from all sectors was the reluctance of fee-for-service providers to join the managed care plan. Plans seemed to have a lot more success with the group practices, the low-income practices. Fee-for-service providers were simply saying no, and this was a major concern. Whether they didn't like the oversight of managed care or reimbursement rates, or wanted to get out of the

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business of Medicaid in general, we don't know. The health plans had some strategies. First of all, health plans said, we need to better market what the benefits of managed care are to beneficiaries and providers to get those providers to join, and we need the power to incentivize providers with higher reimbursement rates and streamlined paperwork. Of course, transfer of beneficiary utilization data a little bit sooner would have helped.

We asked all organizations what was the impact on your organization to help other organizations going through these same transitions to better plan? Most of the organizations we talked to said that there were some changes in their resources. Some health plans said that the reimbursements rates did not reflect the higher utilization of mandatory SPD beneficiaries. Some of the provider clinics had no trouble accommodating an influx of new SPD beneficiaries, but others said our practices were already overburdened. "Our scheduling was already overburdened, and now we have this influx of new patients who are requiring many more appointments, more urgent care appointments, and longer time slots."

We had providers saying that they were providing uncompensated care. A cancer center said, "you know, if a patient was transitioned to a plan we wouldn't work with, we continued with their cancer treatment."

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There are also challenges for community-based organizations, like independent living centers that were serving segments of the SPD population already, who were helping beneficiaries during the transition process. That's who the beneficiaries brought the letter to, and these organizations were providing care.

One of the biggest recommendations or strategies here was to collaborate more with the community-based organizations that were already serving segments of the SPD population. Also, provider groups said, "if I could do it again, I would restructure appointment times. I'd make more urgent care appointments, longer time slots for the new incoming beneficiaries."

Finally, we can't talk about this transition without talking about increasing care coordination, because it was one of the main requirements of the 1115 Waiver to coordinate care better for SPD beneficiaries. Almost every entity we talked to said, "yes, we are spending more time on care coordination," but they also said that the transition was causing more needs for care coordination. Primary care providers said, "we're spending a lot of time on authorization and denial appeals and not enough time on true care coordination," and some of them said, "we're not trained to do this". Health plans increased their member services hours and their member services staff.

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Again, community-based organizations were providing a lot of that care coordination but weren't officially engaged. Community-based organizations said, "we want to be engaged. We want to be engaged with both notification of beneficiaries and assisting during the transition."

Some other strategies were just training for PCPs, in how to provide care coordination and training for other non-physician staff in offices to do some of that authorization and appeal/deny paperwork.

Looking ahead, though managed care does have the potential to increase care coordination, increase access to care for beneficiaries with complex care needs, I think you always have to take into account that there will be disruptions in care, at least initially. Key steps we've identified in this research that can help other plans – other states implementing these kinds of transitions to managed care for patients with complex care needs: the earlier transfer of beneficiary fee-for-service utilization data, or at least a lag time between when the beneficiaries use the plan; anticipating these challenges to expanding provider networks and having plans ready with marketing strategies to increase the number of providers who will say "yes"; and anticipating changes in the beneficiary population and making those structural changes to your resources ahead of time.

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I think one of the biggest successes of this transition that we saw in the counties we studied were these collaborations across organizations that were beginning to develop. We had health plans saying, "we are collaborating with community-based organizations for the first time and we're all wondering why we weren't doing this all along". We had health plans saying – we had community-based organizations saying that the health plans came in, they embraced our population and they helped us through this transition. That is, to end on a positive note, one of the big successes of this transition.

DIANE ROWLAND: Thank you very much, Carrie. Now, we are going to turn, I hope, to Jane Ogle, from California. There she is.

JANE OGLE: Good morning. Thank you very much – or, good afternoon, I guess it is there. Thanks to Carrie for the wonderful work that she did on the surveying about the impact of the transition of seniors and persons with disabilities.

I just wanted to start by saying a little bit about what we're doing in California. As you know, we're one of the 15 states that was elected to participate in the coordinating care demonstration – the dual demonstration of transitioning dual-eligibles into managed care. As a state, we're also moving into managed care in a fairly broad way. We're expanding managed care to the 28 rural counties that have not

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had Medi-Cal managed care in the past. We're also looking at the transition of the Low Income Health Program, the early expansion of Medi-Cal, the childless adults, and their transition into managed care in January of 2014 as we move into health care reform. Then, of course, we're looking at the newly eligible population being moved into managed care.

We have a lot of growth anticipated in the managed care arena, and we're taking very much to heart some of the lessons that we've learned through Carrie's survey of the seniors and persons with disabilities experience. I'll just go through a couple of things that we have seen and we think were very important, from what she described to us.

I think one of the most important things, and Howard will probably say this too, is data and making sure that the plans have data and information in a timely way. For the dual population, in particular, we are going to be able to enroll them in the plan 60 days before they actually become active members of the plan. That will allow us to get the plans data about the members before they actually begin providing services to them. I think that's going to have a huge impact on the ability, day one, to provide services to those members as they roll into the plan according to their birth months.

The other thing I think is very important that we learned is adequate provider network. Right now, for the Coordinated Care Initiative demonstration in eight counties,

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we're working with CMS to evaluate the plan readiness. The next step of that plan readiness evaluation will be looking at the provider network and finding out whether or not the plans have a sufficient network for the number of enrollees that we anticipate being transitioned into the plans.

As Carrie said, for the Coordinated Care Initiative, there are up to about 500,000 people – 456,000 people – who are potentially eligible to enroll in these plans, and we want to make sure that the networks are adequate to receive those people into the plans.

What we've been doing with the plans, as a state with community-based organizations and with the medical societies and the provider associations, is doing a lot of outreach, doing a lot of talking to the providers, explaining this to them, educating providers of all types about this new demonstration project and helping them to understand the benefits to them and to their patients of joining the Coordinated Care Initiative.

We've spent a lot of time, both here at the state-level, and, certainly, at the plan-level, doing provider outreach about the Coordinated Care Initiative, because we've said all along, this isn't about taking a Medi-Cal network and squeezing Medicare enrollees into it. It's about expanding the network to allow Medicare enrollees to continue to see the

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types of providers they've seen in the past, but in a coordinated manner.

We really believe that helping people out to get coordinated care through one-stop shopping through a health plan is better quality care, provides better access, and, frankly, will be more cost-effective over time. That's a major focus of what we're doing right now as we prepare for the go-live in January.

As Carrie said, one of the big issues that we faced in the transition of seniors and persons with disabilities was understanding the impact it would have, in terms of rates on the plans, and that's been an ongoing discussion that I know Howard will be happy to talk about. Discussing with the plans how to get to the right rate for the seniors and persons with disabilities.

Now, that's flowing over into the discussion about how to get to the right rate for the Low Income Health Program people, for the other childless adult expansion population and, of course, for the Coordinated Care Initiative, where the plans will be receiving three different rates; one from Medicare for Parts A and B, another from Medicare for Part D, and then a third from the state for the long-term services and supports, including personal care services, MSSP [Multipurpose Senior Services Program], adult day care services, and nursing

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facility services, all of which the plans will be responsible for under the Coordinated Care Initiative.

I would say the other thing that Carrie mentioned that we really took to heart was collaboration with community-based organizations, and while the state has done a lot of work with the state-level advocates and organizations, I have to really credit the plans on a county-by-county basis for really reaching out to all of the different community-based organizations who work with the seniors and persons with disabilities and with the dual population to understand what their needs are on the social side, not necessarily the medical side, but really bringing those social services into the plans to have conversations about what's going to be necessary to maintain people in their homes and in the community.

I've been to meetings of the community-based organizations in Orange, in Santa Clara, in Los Angeles, and in Alameda. They've really done an excellent job of reaching out to the CBOs as we move forward.

Finally, I think an issue that is one that we're really starting to focus on now is the preparation of the plans for this care coordination and the case management that will be needed for both the Low Income Health Program people transitioning and the dual population transitioning. So part of plan readiness was the NORC organization looking at the plans to see what their readiness is for care coordination and

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collaboration. We will be going back and talking with the plans about what that looks like.

In the very beginning, they all submitted to us models of care that describe how they intended to do care coordination, but now we are really looking at how many care coordinators are needed, what kinds of services are needed, how they're going to integrate the in-home support services, and they're already doing what we call CBAS, Community-Based Adult Services, but how that's all going to be integrated at a plan level for the individual beneficiary, how the integrated care coordination team is going to work, who is going to participate in those teams, how they're going to make sure that they provide sufficient outreach to all of the people who should be participating to assure that a person has a patient-centered care plan that's being developed, and how they're making sure that they're hearing from those members through advisory boards and through other ongoing outlets for them to be in contact with both the members and providers about how the coordinated care initiative is doing and moving forward.

I think one thing that's really important to remember about all of these transitions is that there's a big quality component to them, and we have worked very hard on making sure that we have things, such as rapid-cycle quality improvement available, that we have HEDIS measures in place that are really looking at changes in behavior, not just – I don't mean not

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just, but not specific disease entities, but ER utilization, readmissions to hospitals, falls in homes or in nursing facilities, decubiti, things that really talk about what kind of quality of care people are receiving, so that will be an important part of what we look at going forward.

I just want to say that we were very appreciative of Carrie's work, because it really did open up a lot of avenues for us to think about for the transition of both the Low Income Health Program population and the dual population into managed care, and we're sort of in the home stretch now. We have six months to go until we have to go live with the dual demonstration and moving the Low Income Health Program population into managed care, and we're getting pretty excited about it. We think that the plans are ready. We feel like the state is getting ready. It's an incredible amount of work, but we're getting very excited about the potential here.

With that, I'll turn it over to Howard.

HOWARD KAHN: I think I'll just sit here because I have no slides and my picture is not on the big screen, so - I wish I were taller at a time like this. Can most of you see me? Okay. Good. Good. Thanks, Jane. Thanks, Diane.

I'm going to give a slightly different perspective. I'll give it from the plans perspective. Let me tell you just a little bit about L.A. Care Health Plan. We are a public

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plan. That is, we are a public agency in Los Angeles County, and we have a stakeholder board of governors that directs us.

I always say that we are a health plan; we are a grant maker, because we do a fair amount of grant-making; and we consider ourselves sort of a public health organization and policy shop as well, and that's all to fulfill our mission. So I don't want to talk too much about us, but just to add that we now have – we only operate in Los Angeles County – and we currently have about 1.2 million members, a little over a million of those members are on Medi-Cal in one county, to give you an idea of the scale in Los Angeles. Very substantial scale is always an issue in Los Angeles. We expected, with this SPD transition, to have about 175,000 seniors and people with disabilities coming into either our plan or our competitor plan, which is a commercial plan, Health Net.

We ended up having about 115,000 new members come in over a 12-month period, and these were all people with, as you heard earlier, a multiple severe health care and behavioral health and social needs. And that is a very relevant point, because folks coming in have a lot of social supports that they need, in addition to the health care.

We had a tremendous amount of growth, and everyone talks about, during health care reform, the physician supply issues. That is important, but I'd actually like to talk about the other human supply issues. The other people that need to

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work in the health care delivery system and in the health plan system, et cetera. As we see this expansion coming forward now, the challenge that that means for all of us to get people to answer the phones, to get nurses to do the case management, to do the authorizations, to process claims, et cetera, because, with our finally reaching the goal of expanding access to health care through Obamacare – and I always say that and say it without any embarrassment at all; I think we will be proud someday to say Obamacare – that what's going to happen, is there's going to be a need for all of those people, and that's a big issue and something that we had to hire up for during the SPD increase and, once again, now with Medicaid expansion and the duals demonstration – which we are one of the sites as well – we see that push to bring people on, bring people on.

One of the big challenges that we had, that was alluded to earlier, was the lack of data in advance. I would say that was the single biggest problem other than dollars, and I'll come back to that, Jane, don't worry. The not having the data in advance meant that, not only were people seeking care during those first couple of weeks before we actually got the data and were able to process it, but we had to assign them to doctors on the day they started. And because the outreach wasn't extensive because the time was so short, 70-percent of the people in Los Angeles County were being assigned, rather than

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choosing their doctors. As a result of that, not having the data, we couldn't tell which doctors they had gone to, or we could have affiliated them with doctors who were in the system. Instead, we were doing it randomly.

All new programs, as they're being developed and implemented, are a mess in the health care field, especially when you do it in a large scale, but not having the data, which was considered to be a HIPAA issue at the time, and not allowing us to have the data, made that that much messier. We averted, I think, a crisis through a lot of hard work by everybody at all levels, but we could have had a crisis.

You always expect those first years to be very difficult, but we need to do the things that make it the least difficult as you can, and getting the data in advance is really important.

I'll touch on dollars briefly, although not to harp on it. We knew that our payment rates were going to be insufficient before the program started, and we made that clear to the state. I think the state came around in the end to recognizing that there was additional funding necessary, but that was after we had been operating a while, and Jane will note that I didn't say they didn't pay us enough, but nonetheless everyone recognized that there was additional funding necessary. We actually did lose a lot of money until

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the rates were adjusted during that first year, as did most of the plans that were involved.

Again, I would emphasize that when you're doing a new program like this, you always expect a mess, because transitions are messy. There's no way to do it perfectly, but you try to minimize those problems. The other thing I would say is that we were required to do health risk assessments, which are fairly in-depth interviews of the patients, either in person or telephonically, about their health status. And I think two things came out of that. One was it's very hard to do a health risk assessment of somebody you don't know how to get hold of, and we didn't have reliable contact information to get a hold of those folks. In LA, it's tough to get to that information, because the scale is just so large and it's such a mobile environment as well, and a lot of your members are homeless. A lot of your members are moving all the time. A lot of them don't have phones, et cetera, et cetera.

In addition to that, we found that the HRAs, I believe, didn't necessarily need to be conducted at the same level of depth with everybody. You really need some screening up front, and then to find out whether or not you need to go in as much depth, depending on the illnesses that the person has. One of the warnings is put in requirements and then re-evaluate those requirements down the road to see whether or not that's something that's still needed. That's not to say HRAs, or

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health risk assessments, aren't very useful, but it's most important to get them to the right people. It's all about targeting.

I would say, in terms of quick lessons learned, a couple of notes on that and then I'll stop. One, the folks who have been serving Medicaid beneficiaries, Medi-Cal beneficiaries in California, for a long time and they've been serving them in Los Angeles now for 15 years under a managed care format and for longer. Say, for example, the clinics – the FQHCs, the qualified clinics – aren't necessarily prepared to serve people with these kinds of challenges and disabilities. They've been serving kids and moms, mostly, for a long time. Certain exceptions to that, and certain of them were ready. We tried to do some work in advance to help them get ready, but there was nothing like the onslaught of people and we found that they were having to change their practices. Many of them didn't have an internist on staff, things like that.

There are some critical things that you can do in advance, and some things that won't become a reality until they actually happen. Let me just stop there and let others speak. Thank you.

DIANE ROWLAND: Well, thank you. I think we've had a really good insight into the lessons of California, and there seems to be a lot of comparability in the remarks that we've

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gotten, which I think is very helpful as we turn to now look at what some of the implications are for future national transitions and what's going on nationally. So we're going to ask Trish Riley to start a discussion.

TRISH RILEY: Thank you. To switch gears, I think, a little bit, and take it from a state perspective, it's important to think of the time we're in. The ACA clearly expedites the transition of Medicaid agencies from a claims processor to a value-based purchaser, which is a pretty profound and fundamental change, certainly one underway. It speeds it with significance. That requires, as Howard points out with the plans, that requires fundamentally different skills and resources at the state level to be able to make these transitions happen.

The ACA invests again in the sort of national commitment to program integrity – lots of money, lots of attention to fraud and abuse. We've failed to spend the same amount of focus on how to administer the programs, how to prevent fraud and abuse, how to really build programs, how to plan for programs. States that have been claims processors need very different kinds of resources, skills, staff to be able to accommodate this changing environment, and I'm not sure we are up to readiness on that, nor – and I'm quite confident that legislatures and advocates and others rarely will advocate

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for more resources for state agencies, and yet to achieve accountability, I think that's a very critical issue.

I also think we're at a crossroads in managed care. What is it? What will it be? What are we managing? I think it was Carrie who mentioned that there are multiple care coordinators. How much can you coordinate care? What is managed care going to be? When you think about the history from a state perspective, across the country, of investments in mothers and children, these are lower costs, of course, largely less complex populations.

While it's hard to make generalizations, they're generally populations that are similar to commercial enrollees. We buy similar services from similar providers. So, it's a very different world than the world of SPDs from a state and national perspective. Think about the SPDs, traditionally served by fee-for-service, much reliance on specialty care, unlike with moms and kids, where the Medicaid agency is working directly with managed care organizations; now there are sister organizations – DD organizations, aging offices, behavioral health agencies – that have very significant roles and responsibilities for these populations, and advocacy groups that attach to these populations. Those agencies, those constituency groups, have their own constituencies and strength within legislatures, making it tough for state agencies to make comprehensive, coordinated policy.

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In many respects, we've created a cottage industry. When you think about the moms-and-kids environment, where you're buying from a sector that serves many of the people, in these SPD services, we have a provider network that is almost wholly, in many respects, Medicaid-financed. They're a very different set of providers. They're a very different set of organized systems of care, and they are very much Medicaid agencies, so it's a very fundamental change.

It seems to me that what that invites in this conversation is if we really believe that the transition we're headed toward is a future of person-centered care, don't we need to manage all the services, and not just the medical services? If we don't, what's the real impact on quality of life, effectiveness of treatment, accountability, and costs and access? If we don't, are we recreating the same problem that we were experiencing with the dual eligibles, with bifurcated responsibilities for clients and the services that they receive and how we really integrate care?

In California, we saw the example from Carrie of the carve-out of behavioral health, sort of. Some behavioral health is carved out. Depression and substance abuse is carved in. What about prescriptions? If we don't think about the person and the person's needs in the SPD community, and cover only their medical care, what have we achieved? I used to joke about this in a home care program that we developed, that we

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would have people who were never lonely because they have so many case managers. And it sometimes seems that we have more structure here than we have really a new system of care.

It seems to me the question is not, as it has been over the last couple of decades, what should we carve in or carve out? It's really how do we develop a patient-centered plan of care? What benefits are included? What outcomes do we expect? What price, what quality, and how to measure it? It seems to me that's truly the crossroads of where we need to move to develop a better system of managing care for these populations.

The issue of data, I'd just close with, I think, is a really complex and terribly, terribly important one. What struck me in the discussion was all the states are struggling with health information exchanges. The promise of a health information exchange to deal with the data issues that California has experienced strikes me as a really great opportunity and a place for states to learn from California and to try to think how do these emerging health information exchanges serve as a hub to achieve the kinds of data that, clearly, plans in California needed faster, sooner, better, more accurately. I'll leave it there.

MARGARET MURRAY: Hello, everyone. Can you hear me in the back? Yes. Okay. Great. I just wanted to start off by giving you a little context for who or what ACAP is. I recognize some faces out there, but I think there's probably a

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lot of people that maybe don't know ACAP is the Association for Community Affiliated Plans. We represent the safety net health plans, which are health plans like Howard's – Howard is actually our chair – that are non-profit and focus primarily on the Medicaid program and a little bit Medicare and a little bit more the exchange, eventually. There are 58 of these plans, and our plans cover about a third of all the people who are in Medicaid managed care.

What I wanted to talk today about is the challenges that are facing these plans as they try and take on these new populations. There are a handful of plans like Howard's that are going to try and do all three, or are doing all three, or will be doing all three. Others are doing either Medicaid, the exchange, or the duals, but there are similar challenges for all of the plans. I wanted to first start with Medicaid, because all of the plans – all of our plans – are in Medicaid. The biggest challenge, though, for our plans in the red states is working with the legislature and the governor to try and get the state to take up the Medicaid expansion, and our plans, especially in Texas and Ohio, but in other states have been very involved in those discussions. And in Arizona we were recently successful in getting that approved. That is really the biggest challenge.

Then, for those plans that are doing the expansion, or even in the states where they're moving the ABDs [aged, blind,

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and disabled] in, one of the big challenges for the plans is the things that Trish and others have already alluded to, is how do you do care management for this population? Some of the trends that we're seeing in our plans are much more face-to-face care management where the plans embed case managers at the provider site, or they actually go to peoples' homes, if people will let them in. A lot of times, people don't want the care managers coming to their homes, but they'll meet them at the McDonalds or libraries, and that is definitely the trend for our plans in how to deal with the case management issues for that top 1 to 5-percent.

Then, also, the big issue is this integration of physical health, behavioral health, and the social needs, and I'll just briefly talk about an example that happened fairly close to here. We have a plan in Maryland, Priority Partners, and they have embedded their case managers at a site at the East Baltimore Medical Center near Hopkins, and we did a site visit there, so we got to meet one of the case managers and a man named Ron Preston, who is just a wonderful guy. He probably only has a high school degree; I'm not sure what his training is. He goes out and works with the beneficiaries that they have identified as highly complex patients.

There was one in particular, he was sent to the hospital. The man had sickle cell anemia, and he was supposed to work with him to make sure that when he got out of the

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hospital he didn't go back. While there, he realized that the real issue was that there were substance abuse issues for the man, so his time was spent trying to get the fellow into rehab. The fellow didn't want to go into rehab, so he had to work with his mother and the whole family as a unit to try and encourage the man to get into the rehab, and then when he finally got a placement and didn't show up, he had to go find him and then work to get him back and forth. Then, when he did finally get him into rehab and the fellow came out, then there were housing issues, and so where was he going to go that night? Was it back to his mom's, or where?

I use that story because, to me, that just basically runs the gamete of what these case managers do on a day-to-day basis. And it's the physical health, the idea is to keep them out of the hospital, but it's the substance abuse and mental health issues that were the real crux of what was driving the problems in his daily life, and then the housing issues, and we see that again and again, the housing.

That's what our plans are struggling with – how to design those programs. What are the right ratios? This fellow, I think, has 30 clients that he is dealing with at any one time.

Another issue the plans deal with is the capacity issue, and I think this had already been alluded to a little bit, but how do you find the providers for those new

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populations coming on? Several of our plans are starting to build their own clinics. In Oregon, Care Oregon, one of our members, had realized there was a problem in East Portland, that they had just not enough providers there. So, they decided to set up their own clinic, which eventually they spun off as a separate stand-alone FQHC. There was another clinic that was going to go out of business, so they put their own staff into the clinic and some of their own capital and were able to prop up the clinic until it could operate on its own.

Next month, Texas Children's Health Plan in Houston is going to be opening up an 18,000-foot clinic, which will be staffed by salaried physicians and nurses, and it will see only members of Texas Children's Health Plan, which is one of the bigger plans in Houston. We're seeing more and more of that, and I anticipate we'll start to see even more.

Then, plans are using technology in really innovative ways. One of my favorite examples is actually at L.A. Care, Howard's plan, where they gave some of their PCPs digital cameras, so that they could take pictures of skin problems and then send those pictures and diagnostic notes to dermatologists and have the dermatologist decide whether something really needed to be seen by a specialist or could be handled in the PCP office with a little bit of advice from the specialist. I forget the findings now, Howard, but you saw at least a quarter of your specialist visits were—

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HOWARD KAHN: About half the specialist visits.

MARGARET MURRAY: Alright, so that's a great example of technology and being able to leverage the providers that you have, but use them more efficiently.

Another big issue for our plans is the churning, both in and out of Medicaid and up and down between Medicaid and the exchange. We have been pushing for several years to get legislation introduced to require states to do 12-month continuous eligibility for adults and kids. Right now, states can do it for kids, and about half the states do provide continuous eligibility for kids, but just last month representatives Barton and Green from Texas introduced a bill that would require states to have mandatory continuous eligibility, so we're thrilled about that bill. It's House 1698, and we're looking for cosponsors and other groups that want to work with us.

TRISH RILEY: Cha-ching.

MARGARET MURRAY: Right, so talk to me afterwards if you're interested in helping our advocacy. Then, I can't leave or talk about Medicaid without talking about actuarial soundness, and Howard already alluded to this and I won't go into it further, but you've got to pay the plans correctly in order for them to pay their providers correctly.

In terms of the exchange, some of the big challenges our plans face are the policies set up to encourage or

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discourage safety net health plans. There was a law passed in Orange County in California which explicitly forbids the Cal-Optima, the Medicaid plan there, from going into the exchange. So that's kind of on the dark side, from our perspective.

Then, the feds have actually been very accommodating and really want all Medicaid plans and, in particular, safety net plans. They want to encourage them to come in. The regs said that even though the law says plans have to be accredited to be on the exchange, the federal regulations will allow states to phase in accreditation, and that's a good thing for our plans because only about half of them are accredited in Medicaid.

Just doing all three – as I said, Howard is doing the trifecta with the duals, the exchange, and Medicaid, but even to do two of those is a huge lift operationally that not all plans are able to – or want to be able to do right now. In part because going into the exchange, it's a new population but it's also a whole new set of business processes for our plans, including, for example, premium billing and to take on this new, very complicated process is, again, a very heavy lift that our plans are working on right now.

Then, of course, the reserve issues too. When you take on these new populations you have to have the reserves for it, and for non-profit plans that can't go to Wall Street, have trouble borrowing money, that's a big lift for them as well.

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All of that being said, those are the challenges. Nineteen of our 58 plans will be on the exchange October 1st, and that's a third of the safety net health plans, so we were thrilled that that was it.

In terms of the duals, the challenges there are very similar, and a lot of this has already been talked about, but just two other challenges that I wanted to throw out there. One is that not all states, obviously, are going to be doing the duals' demos. Arizona and New Jersey, in particular, want to put the duals into managed care, but they're going to be using the vehicle of the special needs plans in Medicare. But that law sunsets at the end of 2015, and in order for the plans to know they're going to be in in 2015, the law has to be reauthorized by this fall. We are advocating to get that law reauthorized.

Risk adjustment is a big issue for the safety net health plans with the duals. Right now, the risk adjustment system probably works okay if you have an average population, but if you're at the tail end and you're only enrolling highly complex people with multiple comorbidities and mental health and substance abuse, the Medicare risk adjustment system does not work well, and so we are trying to get that changed as well.

You can see there are a lot of challenges. I really admire our plans, like Howard's, that are going for it, but we

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will come back. Hopefully, you'll be inviting us back to talk about how things went in 2014, and I think in 2015 we expect to see even more safety net health plans in the exchange. Thank you.

DIANE ROWLAND: Thank you, Meg. Now, Kevin.

KEVIN PRINDIVILLE: Great. Well, thank you everyone. I thought I'd start with a little bit of context about the National Senior Citizens Law Center that hopefully will soften my other comments. At NSCLC, we're a national legal advocacy group that has, for many decades, worked on behalf of poor seniors that receive Medicaid and Medicare services.

For the last several years, we've been very engaged in California, where we have two offices, as well as at the federal level and with advocates from other states in the development of the dual-eligible demonstrations, and looking at similar transitions of the senior and persons with disability population into managed care for medical services or, increasingly, for other services too, especially long-term services and supports.

We have been listening to the people that are on the ground helping seniors and people with disabilities through these transitions, and one of the things that really pops out to me reading the paper, and having worked on these issues now for several years in a very intense framework, is that the rhetoric of what we're shooting for is one that we all support,

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right? Improving care, increasing access to care, improving quality, decreasing costs, creating an integrated, as Jane said, one-stop shop for care. Those are things I want to be clear that we at NSCLC and other advocate groups support.

The problem is that the reality that we're seeing as things play out on the ground doesn't always match that rhetoric. The reality that this paper demonstrated, the lack of data exchanges that most people didn't get the health risk assessment that they were owed. The responsibility for providing services remains really fragmented. We say that it has gotten integrated, that it's in a managed care plan, but then that's all delegated to different providers. We need community-based organizations to do this, and this provider group to do that, and another group to do that. The care continuity standards that are supposed to protect peoples' access to providers didn't work in the SPD transition. The networks weren't ready. The financing wasn't right. It's not clear how much money we can save through these models.

The reality of the paper reflects the reality that we saw play out on the ground in our work with advocates that were serving seniors directly. When we talk about these transitions being difficult, we all recognize that transitions are going to be hard. There are going to be problems, but we need to remember there are real lives at the back of that mess. We heard stories of peoples' cancer treatments stopping mid-course

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because the transition occurred. We heard stories of people losing access to prescription drugs that were important to them. We heard stories of people losing access to durable medical equipment that they relied on to stay safe and independent in their homes.

The thing that saves those – that comes up in the paper – the thing that saves people from dying is good will, the willingness of providers to provide uncompensated care. We think that's not good enough, so when we think about lessons learned, we need to build systems for such a vulnerable population that don't rely on good will, but really are smart systems with true safety nets to guide us through the problems that will arise.

The other kind of question that echoes in my mind is – is anyone listening? There have been numerous studies that have shown that there have been problems with these transitions. We've lived through a lot of transitions of this population, and they usually don't go very well. Are we really learning these lessons and turning them into changes to the policies that will make sure that these people are protected through the transition and ongoing?

As Jane mentioned, and Howard, in California there have been a lot of meetings. We have all spent a lot of time in rooms together talking about problems. That's definitely one of the positive things that has occurred. We have people

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speaking with one another that haven't spoken before recognizing the value that health plans bring, the value that different types of providers and CBOs bring to the table, so that has been very positive. Some plans and providers are better about engaging in those discussions than others, so we see some plans in some counties working much more aggressively with stakeholders to develop more robust programs.

We've also found that the plans that seem to do this the best are also the ones that are most humble about how far they have to go and about how much there is still to learn, so that's been a positive.

On the negative, we see a lot of the same policies repeating themselves. On care continuity, the state just released a draft of new care continuity rules for various transitions that are happening in the state, and they mostly just mirror the care continuity rules that didn't work in the SPD transition.

We see the speed of the demonstration. It was slowed down. The implementation date was delayed, but if you look at the date that the 1115 Waiver was approved and the date that the SPD enrollment started, and if you look at the date that the duals MOU was approved and the date that they're now scheduled to start, it's about the same timeframe. The size of the duals demonstration has shrunk, but it's still much bigger

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than the size of the population that was transitioned in the SPD population.

The duals is going to be harder. These data problems – you now introduce another payer into the system, you introduce more providers into the system, it's a bigger population. It's a more complex population in many ways, so everything gets harder. We know that there have been a lot of problems, but we don't see a lot of change in the policies that will address that. To Trish's point, we don't think it's for lack of trying or for a lack of desire to get it right or a lack of care about the population. What we do see is a state agency, and we see this, hear about this in other states as well – that it's slammed with lots of responsibilities, lots of new programs to implement, lots of changes. At the same time, a legislature that has taken money and resources away from their staffing, and it's a lot for any person or any group of people to take on all of these things at once.

As advocates, we continue to be supportive of the promise of these models of where the system is headed, but we also have a concern that we haven't properly learned lessons, and that we aren't really properly resourced and prepared to move forward with the size and the speed that things are moving.

DIANE ROWLAND: I think we're going to have Jane come back on the screen. There you are. We're going to open this

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up now to questions and comments. If you would please raise your hand if you have a question, and we will try to get a mic to you.

We've covered a lot of ground, and so if your question relates to a particular individual, you might identify that. Otherwise, the panel will respond as they can.

ERIC ARBORS: Thank you for this meeting. I'm Eric Arbors from Johns Hopkins University. My question might be best directed to Mr. Kahn. I'm particularly interested in the latitude that you, as a plan, have in negotiating access to, or informing provider networks with, primary care physicians. How much latitude do you have in negotiating on price or on other characteristics?

My second part of that question is do you tend to form networks with primary care providers that are very distinct from the networks that are in the private insurance population, or do you actually have some access to, sort of, what we would call mainstream providers, and how difficult it is for you to – or, in your experience, how difficult has it been for you to sort of contract with those types of providers, particularly for primary care services? Thank you.

HOWARD KAHN: Sure, and I can be very brief about that. California is, unfortunately, one of the lowest-paying states in the country in terms of how much it pays doctors on the Medicaid program. And so, as a result of that, the money we

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receive is among the lowest in the country. What that has resulted in is that you do have almost dedicated networks of physicians that serve mostly low-income population. Also, our populations are naturally in low-income areas, and the doctors in there serve mostly low-income patients because of their location. However, we have been able to move some of the money into primary care through the IPAs or the groups that we work with, and we've been able to keep up the access to primary care.

The bigger problem is actually specialty care access. Most of the mainstream, though, to answer your other question, mainstream physicians in California do not take – at least in Los Angeles, I should say – do not take Medi-Cal patients into their practices in any great numbers at all. That will vary by state because the state payment rates can vary quite a bit, too. Jane, is that fair?

JANE OGLE: Yes, I think that's – we understand and appreciate – wait a second. This is not a time for somebody to be calling me. Sorry.

DIANE ROWLAND: It's probably about payment rates.

JANE OGLE: We understand and appreciate that the rates are difficult, and they have been in California. The plans have done an excellent job of contracting and bringing together networks of primary care providers. We do think that for the coordinated care initiative we'll be looking at Medicare rates

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for those providers, and that will give us a different opportunity than probably currently exists for expanding the network, because I think most providers are pretty used to Medicare rates and the Medicare fee schedule as something that they can work with, so I think that will alleviate some of it for the dual population, at least.

HOWARD KAHN: I should just add, the changes from health care reform, the ACA, in improving primary care physician reimbursement to Medicare levels is going to be, in a place like California, potentially huge. Very important to us, very positive.

DIANE ROWLAND: Okay. Next question. Do we have another question?

PAMELA THORBURN: Hi. I just have a basic question. Right—how many—

DIANE ROWLAND: Could you identify yourself?

PAMELA THORBURN: Oh, sorry. My name is Pamela Thorburn. I'm with the National Community Pharmacists Association. How many states right now do Medicaid managed care, and do you anticipate all states moving to it?

DIANE ROWLAND: Julia?

JULIA PARADISE: I think—

DIANE ROWLAND: Mic.

JULIA PARADISE: Yes. I think at last count there were at least 38 states with risk-based managed care organizations.

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That number is already getting old. That's from a 2010 survey and may be greater at this point. There has been activity just in the last 6-12 months in states moving toward managed care from fee-for-service, for at least some of their beneficiary population.

DIANE ROWLAND: Other questions? Yes.

ZEREANA JESS-HUFF: Hi. I'm Dr. Zereana Jess-Huff. I'm the CEO with ValueOptions in Maryland. My question, I think, probably would be best addressed by Mr. Kahn. My question is, in the transitions that you've been through, have you found, or have you completed a postmortem after these transitions where you've identified what the challenges were? And have you been able to communicate those back to the state and sit down with state stakeholders to talk about that to, I guess, better effectively transition in the future?

HOWARD KAHN: I'm laughing. First off, I probably wouldn't refer to it as a postmortem.

DIANE ROWLAND: That's what they feel like.

HOWARD KAHN: Yes. No, they are difficult transitions, and I've done this before. I started a health plan – Health Plan of San Mateo – when I was 30, and it was the same kind of transition process, and that's why I say somewhat knowledgeably they're always kind of hellish. You try to improve them each time. Yes, we've had extensive conversations with the state and some occasional yelling matches in both directions about

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how important some of the data issues are, the smoothness of transition, timing it right. I always said with the SPDs—we talked about it for six years and did it in six months. That's probably not the way it should really be done, but we have talked through that and I think there's a level of commitment at the state, for example, and hopefully at the federal level, to do it a little differently this next time. We'll see, because at least this time I think the language is no earlier than January for the duals transition, so there's already some flex in there, I think, which we'll be pushing.

DIANE ROWLAND: Trish?

TRISH RILEY: I want to offer a different perspective, dangerous though it might be. Since we're about to see the biggest transition we can imagine on January 1st, as the ACA becomes law, I think it's quite correct. The transitions are always painful, always messy. I think of Part D and where I spent New Year's Eve as that mess unfolded, but it turned out to be a terrific benefit. I think we all ought to be ready for the first, but also recognize there's something valuable about transition chaos. If you plan and plan and plan, it goes off the agenda. As long as there's a sense of chaos and of transition trauma, you have the focused attention of the people who can make change. As painful and horrible as it is, it also is a way to assure the resources, the attention, and the change that needs to happen as these things work through. Pollyanna.

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DIANE ROWLAND: I think we clearly heard today that from the transition that just occurred there have been lessons about what needs to happen in the future, and I think one of the things that causes us to try to do these studies, as well as to bring together these forum, is so that we don't repeat the same mistakes over and over, but really learn from them.

I thank Jane from California for telling us how she has taken to heart some of the lessons and applied them in policy, and I know we're going to see, as Trish said, many more difficult days of transition ahead on multiple fronts. But, hopefully, the mess will become something better and we'll learn from it and we can achieve, at the end, that the reality matches the rhetoric of what we've talked about. Other questions, from the back?

DEBRA LIPSON: Hello. I'm Debra Lipson with Mathematica Policy Research. This is not quite what keeps you up at night, but given the vulnerabilities that Trish talked about in states' oversight capacity and some of the huge issues that are involved in effective oversight, I'm just wondering if there's a couple of areas, either from Jane's perspective, from Trish's perspective, others on the panel, about across the country, which are the key skills, data, information that states most need to improve their capacity to do a good job? Is it in quality measures and quality systems to be able to gather that information, to monitor quality on a more real-time

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basis? Is it contracting? That contract is the basis for accountability. Do states do a good job? Do they need more help on that? Is it rates? Setting the appropriate rates and doing adequate risk adjustment. Just wondering if there are perspectives. Hard to generalize across states, of course, but just wondering if you see a certain set of skills or capacities that are critical to try and build and address.

TRISH RILEY: Hi, Debra. I think it's fair to say generally across the states there may well be agreement on one area, and that is the need for data analytics. It's not just the difficulty of getting the data. It's what do you do with it. I think that's the paramount question, because it affects contracting. It affects quality. I would say if I had to choose one thing, that would be it.

DIANE ROWLAND: And Jane?

JANE OGLE: I think what keeps me up is the care coordination piece of it, because that's the promise of what we're trying to do – to provide people an integrated delivery system and care coordination. Both CMS and the state have been very focused on that, but actual boots-on-the-ground out doing the work and finding the members and making sure that they have coordinated care is going to be a challenge, just in terms of having enough bodies to do it, I think. That's something that I worry about a great deal.

DIANE ROWLAND: Okay.

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MARGARET MURRAY: Just to add to that also, I think it's important that we be able to measure both the new system, which is mostly managed care, and most states do require HEDIS and CAPS and a lot of them require accreditation on the managed care side, but there's very little of that on the fee-for-service side, so we want to make sure also that we are measuring this new system against the reality of the old system, as opposed to the preferred nirvana of what it should be, although we should always keep our eye on the prize. That's one of things we've been trying to get, is to encourage states to measure their fee-for-service programs like they measure their managed care program.

DIANE ROWLAND: But isn't there also a challenge that, as we move to more long-term services and supports being in these plans and more behavioral health, that there are less performance measures there? We really need to also think about what it is we want to measure and hold people accountable for. Kevin?

KEVIN PRINDIVILLE: I would chime in. I think advocates see the thing that states need to redesign themselves around is the ability to provide oversight and monitoring of health plans. It's something we think the Medicare program has been pretty good about, the way that they provide oversight and monitoring of Medicare Advantage plans. They have good data, they react quickly to problems, they take action against plans

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that aren't performing. We think states need to develop a similar capacity to do that, and states that have been working in a fee-for-service system, they don't have the expertise to do that. They don't have the staff to do that or the program to do that, so they've got to be building that internal capacity while also designing the program and contracting and launching the program.

DIANE ROWLAND: Okay. We have a question out here.

MIKE SHEA: Yes. No?

DIANE ROWLAND: Oh.

MIKE SHEA: Oh. Sorry. I didn't know the etiquette.

Going back to—

DIANE ROWLAND: The first etiquette is that you have to identify yourself.

MIKE SHEA: Okay. I'll start all over again. Hi, I'm Mike Shea and I'm with the League of Voluntary Hospitals under partnership with 1199 SEIU. The question that I have is from something that Kevin said earlier, which is — in the experience that — the kind of deficiencies that were discovered in the research has real-life implications for seniors. It hurts the individuals at times — I believe you said, Kevin — that yet there is no evidence on improved clinical outcomes or on cost savings. And, if I understood that point correctly, the idea of managed care is, through coordination and other mechanisms, to

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improve outcomes and to reduce costs. Is there yet any evidence of that?

HOWARD KAHN: I'm going to speak for the state of California, and then Jane can tell me if I'm lying. I think it's fair to say that the state of California has shown evidence that, in moving the SPDs to the Medi-Cal managed care, there has been some significant cost savings. Proof of that would be that they are willing to continue to move more populations there.

I would caution that we struggle with efficacy and demonstrating changes in health status throughout our system, and I mean that – not managed care – I mean the health care delivery system. One of the values of managed care is it's the first time that we've actually started to measure the outcomes of some of these public programs. Whereas in Medicaid, for example, it's never been really measured in an objective, long-term way.

MARGARET MURRAY: I would say, also, on the moms and kids side, which we have more history of that, the HEDIS scores are continuing to go up every year. There are even places where the Medicaid HEDIS scores are better than commercial. I mean, that's anomalous, but it does happen. The ABDs haven't been in as long and, as Diane said, the quality metrics are not as good for that population, although we're working on that.

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For the moms and kids, we have definitely seen improvements in quality.

DIANE ROWLAND: Jane, do you have a comment?

JANE OGLE: I would just say that we believe that, through the managed care plans, we've improved access, because we certainly don't have wonderful data on access in the future service world in Medi-Cal, but we do know about access in the managed care world. While, as Howard said, there were some bumps to begin with, I think now that we're a year or so into it, we have seen - it's been relatively smooth and quiet since the initial bumps. Access has improved. People are getting in to care.

KEVIN PRINDIVILLE: I think there have, actually, been some studies done about - from beneficiary surveys of their perception of access and quality, and I think my recollection of the surveys was that there was a group that said that it improved, there was a group that said it didn't improve, and most people said they didn't really see a change. It's sort of up to your perspective whether to take the one side of the spectrum and then take the middle with it and say overall things either didn't change or got better, or overall things didn't change or got worse. I think that there just isn't a lot of data out yet.

Still, when these conversations first started about how well SNPs were doing, and what do we know about the DSNP

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experience, and what needed to be improved to get to a better place, I think we still don't have great data which shows us what the impact has been on access on quality, on cost savings. I think it's mixed and it's from state to state, and it's mixed in the Medicare program and mixed when you integrate the two, and mixed in Medicaid, so there are a lot of variables we don't, I think, have. It would be nice to have an answer. Does it improve care? Does it decrease costs? I don't think we can definitively answer that question right now.

DIANE ROWLAND: Carrie?

CARRIE GRAHAM: I can't speak to clinical outcomes, but our group at UC Berkeley did conduct a retrospective survey of beneficiaries who had transitioned, and we found that about three-quarters generally in different areas of care self-reported that care was about the same, or better, in managed care. Then you have this 25 to 30-percent in different areas saying that care was worse, and the question is who are those people? Especially in the SPD population, it's hard to generalize.

If there's anything that you can say about the SPD population, it's that they are diverse and they have diverse needs. What we're doing right now, with the help of the state, is we're drilling down on those people who said that they are having worse experiences in areas like pharmacy benefits or mental health care, and we're trying to look at associations

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between that and things like conditions between length of time in managed care, different plans. We'll have those results out soon, but that's a retrospective survey.

DIANE ROWLAND: Great. Well, I think clearly what the survey that we conducted with Carrie and the studies that we've talked about today, experience we've brought together, shows that, to go back to Howard's comment, transitions are always messy. Some are messier than others, and I hope that today's session has helped to lay out some issues for other states following California, as well as for next steps with these populations that can help smooth these transitions and really make the care that we know people deserve who have these complex health care needs the kind of quality care and coordinated care that we all hope happens. But it's not going to be easy, so let's all continue to work together. Let's learn from each other; researchers like to hear this, that more research is always helpful.

Let's end the session by thanking the panel and by staying in touch with them. Thank you.

Jane, thank you so much for joining us from California. We wish you could have been here with us, but you were with us totally on three big screens. Thank you.

JANE OGLE: Thank you. Bye-bye now.

[END 062513_kff_managedcare_audio.mp3]

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